**South Dakota Board of Nursing**
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

# UMA Nursing Student Waiver Application

If any of the information is incorrect, incomplete or illegible, processing may be delayed. An applicant will be notified if additional information is required. **Mail this completed application to the address listed above or email to Ashley.Kroger@state.sd.us.**

***Allow up to 5-7 business days** for the SDBON to process your application, upon approval the BON will email the approved proctor the access information to allow you to take the SDBON online exam.**

***Please Print***

**Name:** First_____ Middle_____ Last _____

Other names previously used:_____

**Mailing Address:**_____ City_____ State_____ Zip_____
Street/PO Box

**Telephone**: Home: (___) _____ Cell: (___) _____ Other: (___) _____

**Email**: _____ **Date of Birth**:_____

**Social Security #**: _____ **Gender**: ❑Male ❑Female

**Ethnicity**: ❑Caucasian ❑Black ❑Hispanic ❑Asian/Pacific Islander ❑American Indian/Alaskan Native ❑Other

**1. High school education information or equivalency information.**

| Name of High School or Equivalency Program | Location of School or Equivalency Program (City, State) | Year Diploma or Equivalency Received |
|---|---|---|
| | | |

**2. I acknowledge that I am *currently* enrolled in the following Nursing School:**

| Name of the approved nursing program I am currently enrolled in: | Location of Nursing Program (City, State): | **Attach copy of school transcript** verifying successful completion of a Pharmacology course and/or a Fundamentals in Nursing Course that includes theory, lab, and clinical in the area of medication administration. |
|---|---|---|
| | | |

**3. RN Attestation.**

*I, _____, RN verify that I completed 4-hours medication administration clinical/lab training with the individual identified on this application, that the applicant is capable of performing all the skills listed on the SD Board of Nursing's approved Skills Competency Checklist safely and competently, and that the applicant is eligible to take the medication aide exam.*

**RN Signature:** _____ **RN License #:** _____ **Date:** _____

**4. SD Board of Nursing Approved Test Proctor Information.**

| Name of SDBON Approved Proctor: | Proctor's Phone: | Proctor's Email Address: |
|---|---|---|
| | | |

**5. Do you currently owe child support arrearages in the sum of $1,000 or more?** ❑YES ❑NO
If YES, contact South Dakota Department of Social Services to make arrangements prior to issuance of med aide registration.

**6. Affidavit**
I, the undersigned, declare and affirm under the penalties of perjury that this application for registration in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

_____ _____
**Medication Aide Applicant Signature** **Date**